IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7005 1160 0000 1506 9544

July 15, 2008

Joseph S. Bleymaier, Administrator
Emmett Rehabilitation & Healthcare
714 North Butte Avenue
Emmett, ID 83617

Provider #: 135020

Dear Mr. Bleymaier:

On **July 7, 2008**, a Recertification and State Licensure survey was conducted at Emmett Rehabilitation & Healthcare, Inc by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be isolated deficiencies that constitute actual harm, but are not an immediate jeopardy, as evidenced by the attached CMS Form 2567L whereby significant corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 28, 2008**. Failure

to submit an acceptable PoC by **July 28, 2008**, may result in the imposition of civil monetary penalties by **August 18, 2008**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 7, 2009**, if substantial compliance is not achieved by that time.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **July 28, 2008**. If your request for informal dispute resolution is received after **July 28, 2008**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135020	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 7/7/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	**714 NORTH BUTTE AVENUE EMMETT, ID**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	483.75(l)(1) CLINICAL RECORDS

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, it was determined the facility failed to provide complete clinical records in accordance with accepted and professional standards. This was true for 1 of 12 sampled residents (#6). Findings include:

Resident #6 was admitted to the facility on 06/12/00, and readmitted on 09/29/04 with diagnoses of Alzheimer's disease with behavioral disturbances, diabetes mellitus type 2, congestive heart failure, depression, Parkinson's disease, and asthma.

The June 2008 comprehensive care plan for Resident #6 indicated,"Nutrition altered r/t (related to) Alzheimer's with wt. (weight) loss expected d/t (due to) disease process, depression, diabetes, diet mech (mechanically) altered d/t (due to) need for thickened liquids and increased risk of dehydration." The care plan also indicated, "provide additional nourishment prn (as needed)," "monitor % (percentage) of food/fluids consumed," and "prevent avoidable wt. (weight) loss."

Resident #6's April, May, and June 2008 MAR (Medication Administration Record) indicated a diabetic snack was to be offered to the resident,"HS (before hour of sleep) Snack offered A=Accepted, R=Refused. Document % (percentage) consumed." No diabetic snack was documented as offered, accepted, or refused by resident on the April MAR for the dates 04/06/08, 04/07/08, 04/09/08, 04/15/08, 04/22/08, 04/29/08, 04/30/08. No snack was documented on the May MAR for the dates 05/05/08, 05/06/08, 05/13/08, 05/20/08, 05/21/08, 05/25/08, 05/29/08. No snack was documented on the June MAR for the dates 06/03/08, 06/08/08, 06/24/08.

The DON was interviewed 07/03/08 at 12:05 pm, and confirmed the HS (before hour of sleep)diabetic snack needed to be documented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey of your facility. The surveyors conducting the survey were: Lorna Bouse, BSW, Team Coordinator Lea Stoltz, QMRP Amanda Bain, RN Rhonda Olsen, RN Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Emmett Rehabilitation & Healthcare does not admit that the deficiencies listed on the CMS Form 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 159 SS=B	483.10(c)(2)-(5) PROTECTION OF RESIDENT FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest	F 159	RECEIVED JUL 28 2008 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Kelly Mayer | ADMINISTRATOR | 07/28/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 159	Continued From page 1 bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on resident interviews obtained during the resident group meeting and an interview with the facility's Administrator, it was determined the facility failed to ensure residents had access to petty cash on an on-going basis, specifically during the weekend. This had the potential to affect any resident who requested money on Saturday or Sunday. The findings include:	F 159	F 159 1. Procedures have been established to ensure residents have access to petty cash funds at all times—including weekends. Written notice was given to all nursing staff on availability and procedures to access. A review of personal records provided all residents who have personal funds maintained by the facility. Letters were sent to all affected residents advising them of procedures to access their personal petty cash during off hours and weekends. Procedures were discussed at resident council meeting and residents acknowledged new procedures. 2. Upon admission, new residents are advised of and acknowledge policy and procedures regarding personal funds maintained by the facility. 3. New policy established outlining procedures to ensure residents can access their petty cash. Business Office Manager (BOM) will check with charge nurse every Monday (1st business day) to determine if access to the funds was made. If access was granted, BOM will charge the resident's account, replenish as necessary, and advise the Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 159	Continued From page 2 During the resident group meeting held on 7/1/08 at 11:30 am, several residents reported that they were unable to obtain money on weekends. Seven residents attended the group meeting and all confirmed that in order to have money on the weekend, the request had to be made on Friday. One resident stated, "You can't get money on the weekend if your family wants to take you shopping." This information was shared with the Administrator at the end of the day on 7/1/08. When asked if funds were available to residents on the weekends, he replied a staff person could be called in from home to obtain funds from the office. On 7/2/08 at 9:00 a.m. the Administrator provided a written response to the issue which stated, "Access to funds - We have initiated a new procedure to place part of the resident petty cash funds in the med room E - board. These funds can be accessed at any time by the charge nurse who has the only key. A log has been developed to track any access, which can be reconciled by the business office on the following business day. Residents are being informed today by letter from the Administrator." Residents did not have access to petty cash on a consistent, on-going basis.	F 159	F 159 (Continued from page 2) Each Monday, BOM will ensure the list of residents with access is current. 4. Resident access to personal funds will be specific topic of discussion at the Resident Council for the next six months. QA Committee will monitor monthly for the next three months, then quarterly thereafter. Date: 7/31/08	
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident group and staff interview, it was determined the facility failed to provide an activities program that met the needs of 1 of 11 (#3) sampled residents and had the potential to affect all other residents. The facility also failed to ensure meaningful activities were provided to residents on weekends. Findings include: 1. Resident #3 was admitted to the facility on 6/1/07 with diagnoses of depressive disorder, congestive heart failure, ulcers of the skin, cellulitis, osteoarthritis and peripheral vein disease. Resident #3 was interviewed on 6/30/08 at 11:00 a.m. During the interview the resident stated he spent most of his time in his room and stated his doctor was "always asking me how my depression is." Resident #3 denied his depression, despite a long history of the disorder and current treatment with antidepressant medications. The May 2008 Care Plan was reviewed and revealed Activities had not been identified as a problem area, and no goals or interventions were in place to address the resident's self isolation. The Activity Director was interviewed on 7/3/08 at 9:45 a.m. When asked about the resident's lack of care planning for activities, she stated there were 2 interventions listed under "alteration in psychosocial well being/mood" which pertained to activities. The interventions were, "Encourage resident to reminisce about past life experiences" and " Encourage regular visits from family &	F 248	F 248 1. Activities program to meet the needs of resident #3 was established by a) defining the problem as the potential for activity deficit related to the resident's preference of self-isolation; and b) defining goals to enhance his quality of life through encouragement of group activities. The goals include: provide 1:1 visits to build rapport and provide social and mental stimulation; encouragement to attend pet days; take pets to his room (if he refuses to come out); offer the sports section of the newspaper daily; encourage communication with staff and residents concerning sports, news and animals (Note: Sport Channels 24-28, News Channel 28, and Animal Channel 44). Staff members (working less than full time) have volunteered to work weekends to provide meaningful activities. These duties have been added to their schedules. Resident Council will be queried to elicit resident preferences for weekend activities. 2. Residents who do not regularly join in group activities are affected. An assessment was done on all residents to determine level of cognition, mood, time awake and percent of participation in activities.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 4 pets." Individual Participation Records for 5/08 and 6/08 were reviewed. One category was titled "Intellectual" and was marked "a" (active) every day in 6/08, indicating the resident had actively participated. When asked what the activity consisted of, the Activity Director stated it was a CNA saying good morning to the resident when they delivered his daily paper to his room. "One to One" was also marked as "active daily." The activity was defined by the Activity director as CNA interactions during routine daily cares. When asked if the resident had been assessed for activity preferences, the Activity Director stated the resident enjoyed visits from pets. There was no documentation present on the frequency of participation in pet visits on the participation records. The facility failed to develop and implement an ongoing activity program for Resident #3 which addressed his need for decreased self isolation and appealed to his interests. 2. A resident group interview was conducted on 7/1/08 at 11:30 a.m. Seven residents attended. When asked about the activity program, the group expressed overall satisfaction with the Monday through Friday offerings. They stated there were not enough activities offered on the weekends. One resident stated residents could have activities materials if they requested them. Another resident stated the movies and popcorn on Saturdays were a "sometimes" event and residents were responsible for running bingo and other activities if they wanted them.	F 248	F 248 (Continued from page 4) From this assessment new care plans for activities are being developed for each resident. Additional staff is now scheduled to assist with meaningful weekend activities. Resident Council will be queried to elicit resident preferences for weekend activities. 3. Inservice given to all employees on importance of interacting with all residents. Meaningful activities will be a monthly agenda item for the Resident Council. Quarterly assessment and care plan update to identify changes in resident status preferences or activity needs. 4. Resident activities will be a special emphasis item for the QA Committee for the next six months. Date: 7/31/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 5 A review of the Activity Schedule for July 2008 showed the following: Saturday 10:00 Movies and popcorn 12:00 Exercise Class 12:20 Combined activity 7:00 Lawrence Welk Sunday 10:15 LDS services 12:20 Reminiscing 3:00 - 8:00 family visits On the third Sunday of the month a Catholic service was offered at 3:00 p.m. The Administrator and Social Services Director were interviewed on 7/2/08 at 10:00 a.m. The Social Services Director stated residents were not expected to run activities, nor were they doing it. The Administrator stated the movies and popcorn were assigned to the CNAs to run on Saturdays and that sometimes they ran the program and sometimes they did not. The Activity Director was interviewed on 7/3/08 at 9:45 a.m. When asked to define "combined activity" and "reminiscing", she stated it was a ball toss or magazine distribution and conversation with staff prior to the noon meal to help residents wake up.	F 248		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined the facility did not ensure maintenance services were provided for room 108 to ensure the residents had a hand washing sink that could be cleaned and sanitized. In addition, screens on resident room windows in rooms 200 and 202 were not flush to the window frame and gaskets on windows had broken seals in rooms 117, 121, 122, 202 and 211. Findings include: 1. Room 108 was observed on 7/1/08 at 7:55 am. Two residents used the room. The hand washing sink was streaked with a dark brown color. When the surveyor attempted to wipe the stain off with a wet paper towel it could not be removed. The stain covered the entire basin of the sink and went over half way up to the top of the sink. The faucets were heavily corroded with mineral deposits. This was unsightly and made the sink difficult to clean and sanitize. The Maintenance Supervisor was interviewed later that day at 9:00 am. He stated that he had used pumice stone on the sink and the stain would not come out. He said that the sink may have porcelain that was worn off. He said that since it was a building with fixtures from the 1960's he had been having difficulty finding a sink that would fit to replace it. On 7/2/08 the Administrator provided an update on what had been done to remedy the problem. The documentation regarding room 108 included, "The sink in room 108 has been replaced. We were able to replace it with an unused sink from the Medical Records office."	F 253	F 253 1. Removed and replaced sink in room 108. Screens in rooms 200 and 202 were repaired or replaced. Windows in rooms 117, 121, 122, 202, and 211 were assessed, cleaned and scheduled for replacement as necessary, 2. Sinks in all rooms were inspected. None other than room 108 was defective. Screens in all rooms were inspected and repaired or replaced as necessary. Windows in all rooms were assessed. Contractor prepared a quote on 7/23/08 to replace defective windows. Defective windows to be replaced by 8/31/08. 3. Inservice for all staff and instructions to housekeeping and nursing staff to log defective sinks (as well as damaged fixtures, furniture, and equipment, or any other environment concerns), screens and window panes in the maintenance log. Windows and screens will be inspected monthly as part of the preventive maintenance program. 4. Corrective actions will be monitored by the maintenance supervisor and the Administrator on an ongoing basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 7 2. Several rooms had double pane windows with leaks around the gaskets that allowed moisture to accumulate between the window panes. This clouded some of the windows so they obscured visibility or caused the windows to be streaked and dirty looking. The following windows were observed on 7/1/08 at approximately 8:15 am to be affected by this problem: Rooms 117, 121 (could not see through largest middle pane), 122, 202 and 211. In addition, screens in rooms 200 and 202 did not fit flush to the frames. This allowed an entry point for flies, mosquitos and other insects to enter when the windows were open. The Administrator observed the windows and screens with the surveyor on 7/3/08 at 10:50 am. (The Maintenance Supervisor was not available on that day). The Administrator agreed that there was a problem with the windows and said some of them had been replaced. He said the facility was having a problem with the manufacturer. He indicated the windows should not be open but the screens could be fixed. The administator was advised windows had been observed open on all days of the survey from 6/30 to 7/308.	F 253	F 253 (Continued from page 7) Windows and screens will be a special interest item for the QA Committee agenda for the next six months. Date: 7/31/08	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:	F 272	F 272 1. Corrective actions implemented for resident #8 include: the assessment for mobility and safety with the wheelchair and the assessment of the ability to self-release the seatbelt independently. 2. Other residents with self-releasing seatbelts and/or other restraining	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 8 Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not assess for mobility and safety prior to equipping a resident with a wheelchair seatbelt physical restraint. This was true for 1 of 11 sampled residents (#8). Findings include: Resident #8 was admitted to the facility on 5/6/08 with diagnoses of brain syndrome with presenile brain disease and asthma. The 5/10/08 admission MDS stated the resident experienced both short and long term memory loss, had moderately impaired cognitive skills for daily decision making, required extensive	F 272	F 272 (Continued from page 8) devices have the potential to be affected. Corrective actions include: assessments of mobility and safety while using seatbelts and/or other restraining devices, and assessments of the ability to self-release the seatbelt and/or other restraining devices independently. 3. Staff have been inserviced about the use of restraints and the assessments required prior to the implementation of the restraining devices. IDT will review all residents with restraints at least quarterly for mobility, safety and the ability to self-release the devices. 4. The corrective actions will be monitored by the DON or designee and reported to the QA Committee on a monthly basis for 3 months and quarterly thereafter. Date: 7/31/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 9 assistance for transfers and that cognitive status had deteriorated. Resident #8's 5/6/08 Plan of Care included a goal to prevent avoidable falls. Interventions to address the fall risk included use of a soft self releasing belt when up in wheelchair and instructions to release the belt and reposition the resident every 2 hours. A 6/2/08 Interdisciplinary Physical Restraint Evaluation for use of the seat belt was reviewed. The evaluation tool did not include documentation the resident had been assessed for safety while the seat belt was in use. Additionally, no documentation was in the resident's record indicating whether or not the resident could release the seatbelt independently. The DON was interviewed on 7/3/08 at 10:30 and confirmed, based on conversations with facility staff, that the resident could not release the seatbelt independently and the resident's safety had been assessed in regard to fall prevention, but not restraint use.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 10 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to revise the residents' comprehensive care plan goal dates for 3 of 11 sampled residents (#2, 3, & 4). Additionally, Resident # 2's care plan had not been revised to include all necessary interventions to prevent falls. Findings include: 1. Resident #2 was admitted to the facility on 11/12/07 with a diagnoses of gastrointestinal hemorrhage, hypertension, chronic back pain, severe osteoporosis, and depression. The resident was readmitted on 2/6/08 with an additional diagnosis of fractured left hip with surgical repair. a. The facility "Nursing Assessment/Full," dated 12/12/07, scored the resident a 16 for fall risk (14 + = High Risk). Interventions for falls on the resident's 1/08 Plan of Care included: *"Non slip rug at bedside." *"Alarms for bed and wheelchair." *"Resident uses call light for assist with transfers." *"Transfer with 1 assist. Encourage to assist with transfer."	F 280	F 280 1. Corrective actions implemented for residents #2, #3, and #4 include: careplans were reviewed; interventions and goal dates were revised as needed. 2. All residents could be potentially affected. Corrective actions include: careplans were reviewed; interventions and goal dates were revised as needed. 3. IDT will review and revise interventions and goal dates with quarterly careplan reviews as needed. Staff inserviced regarding the need to add, delete or revise interventions as appropriate and to ensure that goal dates are appropriate. Medical Records staff will review goal dates during data entry process and alert IDT of goal dates requiring attention. 4. Corrective actions will be monitored through a monthly careplan audit. Random chart audits will be completed to ensure careplans reflect current status and interventions. Results will be reported to the monthly QA Committee for 3 months, then quarterly thereafter. Date: 7/31/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 11 The Resident Incident/Accident Report indicated the resident had a fall with subsequent hip fracture on 2/2/08. The report documented the resident fell after attempting to get from the bathroom to the bed without assistance. The resident returned to the facility on 2/6/08 following surgical repair of the hip fracture. Transfer with 1 assist was discontinued from the care plan and "2 person ext. [extensive] assist /c [with] transfers" was added as an intervention to prevent falls on 2/13/08. Considering the circumstances of the resident's fall/injury, an intervention such as, "Do not leave unattended on toilet/commode," was appropriate but was not added. Omission of that intervention left the resident vulnerable to inadequate supervision and assistance. b. The resident's most current Plan of Care, dated 5/08, contained several expired goal dates: 3 for February, 7 for March, 2 for April, and 3 for May. Five other goals on the care plan were updated to August. 2. Resident #4 was admitted to the facility on 12/17/07 with diagnoses of diabetes mellitus Type II, chronic ischemic heart disease, atrial fibrillation, congestive heart failure. The resident's most current Plan of Care, dated 6/08, contained several expired goal dates: 2 for February, 7 for March, and 7 for April. Two estimated goal dates were for August. The RN consultant was interviewed on 7/3/08 at 10:00 am. She stated the facility had been experiencing a difficult transition to a new care	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 12 plan data base since October. The nurse consultant acknowledged the care plans had not been updated as needed. She stated the problem was resolving as the staff became more familiar with the data base. 3. Resident #3 was admitted to the facility on 6/1/07 with diagnoses of depressive disorder, congestive heart failure, ulcers of the skin, cellulitis, osteoarthritis and peripheral vein disease. Resident #3's May 2008 Plan of Care included goals to address activities of daily living, self care deficits, physical mobility, nutrition, psychosocial well-being, alteration in communication, advanced directives and pain/comfort. All of the goals had completion dates of 3/13/08 or prior dates. Two goals, skin integrity and edema, had goal dates of 7/28/08. The DON was interviewed on 7/2/08 at 10:00 a.m. and confirmed the care plan did not have current goal dates. This is a repeat deficiency from the annual recertification survey for 3/23/07.	F 280		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it was determined the facility did not ensure that professional standards for clarifying physician orders was initiated by nursing staff for 1 of 1	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 13 sample resident (#10) with an order for oxygen treatment. Findings include: Reference: Elkin, Perry, Potter, Nursing Interventions & Clincal Skill, 3rd Edition, inside cover: "Quick Reference to Standard Protocols for All Nursing Interventions... 1. Verify physician's orders if skill is a dependent or collaborative nursing intervention..." And page 750, "...Oxygen is a medication and should not be adjusted without a physician's order." Resident #10 was readmitted to the facility on 6/4/08 with diagnoses that included heart failure and chronic airway obstruction. The physician orders recapitulation for the month of July 2008 documented an order for, "Oxygen 3 - 5 [Liters per minute per nasal canula]." There were no parameters given for titration of the liter flow for the oxygen and needed clarification with the physician. The DON was interviewed regarding the order on 7/3/08 at 12:00 pm. She reviewed the order in the resident's record and said it was not clear and should have been clarified with the physician. This is a repeat deficiency from the annual recertification survey of 3/23/07.	F 281	F 281 1. Corrective actions implemented for resident #10 include: physician orders were clarified to include parameters for titration of the liter flow. 2. All residents receiving oxygen could potentially be affected. Corrective actions implemented for residents receiving oxygen include: an audit was completed to identify residents with oxygen orders; clarification orders were obtained including parameters for titration of the liter flow. 3. Staff were inserviced about obtaining complete physician orders regarding oxygen, liter flow and titration parameters. Ongoing quarterly inservices planned for the next 6 months and then PRN to ensure compliance. Monthly monitoring of orders will be accomplished through the recap process.	
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	4. Corrective actions will be monitored by the DON and reported to the QA Committee monthly for 3 months, then quarterly thereafter. Date: 7/31/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview the facility failed to ensure that 1 of 12 sampled residents (Resident #7) who was unable to carry out activities of daily living received the necessary services to maintain good nutrition. Findings include: Resident # 7 was admitted to the facility on 03/03/06, and readmitted on 05/22/08 with the diagnoses of cerebral palsy, mental retardation, and depression. The 05/08/08 Quarterly MDS Assessment for Resident #7, under the category of ADL self performance, stated the resident required supervision with eating. Resident #7's June 2008 comprehensive care plan stated, "encourage oral intake,"at meals. The April and May 2008 Nurses ADL flow sheets documented the resident required eating assistance as follows, "Supervision-oversight, encouragement or cueing," and,"Limited assist-resident highly involved; received physical help in moving limbs or other non-wt (weight) bearing assist." On 07/01/08 at 07:45 am, Resident #7 was observed asleep in her wheelchair in the Cherry Blossom dining room. There were a total of four CNA's present during the entire meal service. At 08:05 am, CNA A woke the resident and advised her that her meal had arrived. The resident fell asleep in her wheelchair. Immediately after the resident fell asleep, the Dietary manager attempted to wake the resident for breakfast without success. The Dietary manager left the	F 312	F 312 1. Corrective actions implemented for resident #7 include: staff were inserviced regarding needs of this resident; careplan was reviewed and revised as needed. 2. All residents requiring supervision or assistance with meals could be affected. Corrective actions implemented include: identification of other residents requiring supervision or assistance with meals; review and revision of careplans, as needed; and staff were inserviced about assisting residents during meals to include offering alternative choices and reheating food as needed. 3. Supervisory staff assigned to monitor dining rooms during meal service to ensure staff are offering assistance required and that residents are offered alternative choices and reheating of meals as needed; and, ongoing CNA education related to meal service and resident needs. 4. Corrective actions will be monitored by IDT, RN supervisors, and RD. Results of audits will be reviewed at monthly QA Committee meetings for 3 months, then quarterly thereafter. Date: 7/31/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 15 dining room. At 08:10 am, CNA A attempted to wake the resident again for breakfast. The resident woke up and took one bite of her cereal. The resident fell asleep with her head resting on the table. The resident remained asleep from 08:15 am to 08:35 am, with her head resting on the table. At 08:35 am, CNA B sat with the resident at the table, woke her, and handed her a cup of juice. The resident refused the juice. CNA B advised the resident that she would return in a while to try again. CNA B left the resident's table to assist with another resident at a different table. Resident #7 fell asleep with her head on the table. At 08:40 am, CNA A instructed the resident to wake up and try to eat, but offered no assistance. The resident remained asleep with her head on the table from 08:40 am to 8:55 am, without any acknowledgement or assistance. At 08:55 am, CNA A sat at the resident's table and did not address the resident. CNA A proceeded to assist a different resident seated at the same table. Approximately a minute later, CNA B returned to the resident's table and woke the resident. CNA B cued, encouraged and assisted the resident to eat her meal. During the meal service, the staff members failed to offer alternatives or to reheat the resident's cereal. The resident finished her cereal when she received the cueing, encouragement and assistance required from staff. The DON, Administrator, and Nurse consultant were interviewed on 07/03/08 at approximately 12:30 pm, and acknowledged the observation.	F 312		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 16 resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and review of facility Resident Incident/Accident Reports, it was determined the facility did not ensure 1 of 1 sample resident (#5) was thoroughly assessed for incontinence so an individualized toileting program could be developed. Findings include: Resident #5 was admitted from the hospital to the facility on 1/11/08 with diagnoses of diabetes, kidney disease, hypertension, coronary artery disease, dementia and history of right shoulder replacement. He was re-admitted on 1/29/08 after a hospitalization to repair a hip fracture after falling at the facility. A facility "Nursing Assessment/Full" form, dated 1/11/08, documented the resident was continent of bowel and bladder and used the toilet for elimination. The admission MDS assessment, dated 1/15/08, documented the resident was moderately cognitively impaired, required limited assistance from one staff for transfers, ambulation, assistance to toilet and was continent of bowel and bladder. The initial care plan was dated 1/15/08 and was a	F 315	F 315 1. Corrective actions implemented for resident #5 include: review and revision of Bladder Assessment; review and revision of careplan to include scheduled toileting plan; and, CNA staff were inserviced regarding his plan of care. 2. All resident experiencing incontinence could be affected. Corrective actions implemented include: audit of all residents' current continence level; review and revision of careplans to include bladder retraining or scheduled toileting plans; and, CNA staff were inserviced about all residents' continence status and needs related to toileting. 3. Resident experiencing incontinence upon admission, or throughout stay will be assessed to determine appropriate interventions, to include individualized toileting schedules, if appropriate. This assessment will include void patterns, where applicable; and, staff inservices were held related to incontinence and interventions to improve or minimize decline in status.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 17 form with listed areas which were indicated (circled/checked) if they applied to the resident. ADL deficit was circled related to toileting assist. It was indicated that all goals were to be met by 2/15/08. However, no goals were indicated and there were no interventions related to toileting assist identified. A revised page of the care plan, dated 1/14/08, again identified self care deficits. An intervention for toileting directed, "Continent, Urinal at bedside. Offer to take to BR [bathroom] 2-3 [times] shift." After the resident was hospitalized for repair of a hip fracture he returned to the facility on 1/29/08. A facility "Nursing Assessment/Full" form included a section for bowel and bladder evaluation. The form checked that he used a urinal and bedpan and that he was continent of bowel and bladder. This was a contradiction to the MDS assessment completed 2/2/08, for a significant change in condition. This assessment documented he needed extensive assistance for transfers and toilet assistance, had moderate pain daily and was totally incontinent of bowel and bladder. The RAP for incontinence triggered and documented, "Urinary incontinence triggered as resident had a Foley [catheter] placed while in the hospital. He is using adult briefs [secondary to] incontinence. Was continent prior. [Increase] may be r/t [related to] decreased mobility/pain. Does have urinal at bedside and will use with assist...Will cp [care plan] need for assist- anticipate continence will improve as pain/mobility improve." The care plan was revised 1/29/08 with an approach for idetified problem of self care deficit. Interventions included, "Frequently incontinent. Urinal at bedside. Offer [every] 2 hours and prn [as needed] while awake. Adult briefs. Provide	F 315	F 315 (Continued from page 17) 4. The DON or designee will monitor the assessments and void pattern documentation for new admissions. The IDT will monitor changes in status and update assessments and careplans on a quarterly basis, and PRN. Results of audits will be reported at the monthly QA Committee meeting for 3 months, then quarterly thereafter. Date: 7/31/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 18 pericare after each incontinent episode." The most current MDS assessment, dated 4/27/08, was for a significant change. The resident was coded as continent of bowel but at a 3 (frequently incontinent) of bladder. He was not coded for any pain. This triggered a RAP for incontinence with documentation as follows: "Urinary incontinence triggers as res[ident] freq[uently] incontinent. Adult protection is used and staff provide peri- hygiene. He has a urinal at bedside and staff toilet routinely. Will cp [care plan] current measures to ensure at highest level of continence and to promote dignity." A facility "Bladder Status Evaluation" form, dated 4/29/08, required check marks for listed areas pertaining to the resident. The history section, indicated check marks that the resident had been incontinent since admission. (This was the case for the readmission only). For urinary status, "No apparent pattern" was checked. (There were no void patterns documented). Under the section for current mental/physical status the following were checked: He was alert and oriented times 2 and cooperative. He was able to respond to his name and communicate his toileting needs. He had a perception of need to void and no bladder distention. For "urge related incontinence" the writer/assessor indicated the resident had to hurry to urinate, and could not always make it to the bathroom on time. The writer documented, "Uses urinal frequently." Under "functional incontinence", the resident was identified to have a need for total assistance with toileting, needed grab bars, no raised toilet seat required, used a urinal and had a fear of falling. Conclusions were that the resident had functional incontinence. Routine toileting was checked for identification of type of	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 19 toilet plan. The care plan, for May 2008 was the same for toileting as above on 1/29/08 with an approach for with a problem for self care deficit. Interventions included, "Frequently incontinent. Urinal at bedside. Offer [every] 2 hours and prn [as needed] while awake. Adult briefs. Provide peri-care after each incontinent episode." A facility "Incident/Accident Report", dated 5/22/08, documented a statement from the resident's spouse who witnessed a fall. "Disoriented or sleepy, [Resident #5] was determined to get up to potty. He was worried about wetting his pants. He had his alarm on and set it off. He was in a big hurry. I ask him to wait and slow down. He did not hurt himself, just slid down against the front of his recliner on his bottom. I caught his fall but could not hold his weight. He had only socks on, no shoes." A care plan update form (5/23/08) documented, "Unaware of own safety issues at times. Has no patience or awareness of need to wait for assistance. Walks fast at times... interventions...When up in recliner or w/c be sure he has on shoes and socks. If refuses shoes he needs non-skid socks. Remind to slow down when amb[ulates] fast." The facility had not determined how the incontinence may have correlated with this accident. On 7/1/08 at 12:00 pm, Resident #5 was observed self propelling his wheel chair up the 100 hall to his room. He was observed to transfer from his wheel chair to his recliner. Only one CNA assisted him and he did very well. He stood up from the wheel chair with very little help and then	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 20 the CNA assisted him to move back and sit down on the recliner. He did move rather quickly and was not sure of his proximity to the chair once he stood up. He told the surveyor he was cold and requested a blanket from the CNA who covered him and then left the room. On 7/2/08 at 2:10 am, the lack of assessment for incontinence for this resident and how it could relate to a fall was communicated to the DON, RN Consultant and the Administrator. There was agreement from the nurses that a void pattern had not been established in the record. The facility did not have interventions in place to restore the resident's urinary continence status. He was not adequately assessed to determine what his individualized toileting program should be. The resident had a total decline in urinary incontinence upon his return to the facility after hip repair for a fracture. This could be expected temporarily, as his functional level had greatly changed due to the fracture and accompanying pain. The resident had improved in functionality with better mobility and less pain since that time. However, he had very little improvement in his urinary incontinence. There had been no connection made between his need to toilet and possible falls from attempts to toilet independently. (See F323, 483.25(h) for additional findings related to falls for this resident). The facility did not meet the intent of this regulation to restore as much normal bladder function as possible. This is a repeat deficiency from the annual recertification survey of 3/23/07.	F 315		
F 323 SS=G	483.25(h) ACCIDENTS AND SUPERVISION	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 21 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and review of facility Resident Incident/Accident Reports, it was determined the facility did not ensure 2 of 10 sample residents (#'s 2 and 5) had safety interventions in place to protect them from falls. Residents #2 and #5 were harmed when they fractured their hips as a result of falls. Findings include: 1. Resident #5 was admitted from the hospital to the facility on 1/11/07 with diagnoses of diabetes, kidney disease, hypertension, coronary artery disease, dementia and history of right shoulder replacement. He was re-admitted on 1/29/08 after a hospitalization to repair a hip fracture after falling at the facility. The History and Physical report, dated 1/8/07, documented, "...presents to emergency room complaining of generalized weakness, slow to respond... reports that he almost fell today and was leaning to the right..." The admission MDS assessment, dated 1/15/08, documented the resident was moderately cognitively impaired, required limited assistance from one staff for transfers and ambulation, there had been no falls. This assessment triggered a	F 323	F 323 1. Corrective actions implemented for residents #2 and #5 include: current Fall Risk scores, as well as careplans were reviewed and revised, as needed; and, room checks were completed to verify ongoing use of fall prevention devices and interventions. 2. All residents could be affected. Corrective actions implemented include: Fall Risk scores, as well as careplans were reviewed and revised, as needed; and, room checks were completed to verify ongoing use of fall prevention devises and interventions. 3. Pre-admission review by IDT to clarify risk factors and implement proactive plan of care. Revision of the facility accident investigation form; implementation of 72 hour observation and documentation period for all new admissions and those experiencing an acute change of condition; staff were inserviced about accident and incident prevention and investigation; and, staff were inserviced about anticipating needs for residents experiencing changes in condition, and implementing interventions for supervision and prevention of accidents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 22 fall RAP that included the following documentation: "Falls triggers as res[ident] has meds in place that may contribute to falls. [No] attempts to self transfer. Is working [with] PT [Physical Therapy] which will improve gait/balance/strength and endurance and [decrease] risk of avoidable falls- Will proceed." The facility "Nursing Assessment/Full" was dated 1/11/08, and scored the resident a 16 for fall risk (14 + = High Risk). A safety device was recommended for "tab alarm." The care plan, dated 1/17/08, documented a problem for "Physical mobility impaired related to recent pneumonia, severe L-S spine DDD [degenerative disk disease]... weakness, fatigue, LE [lower extremity] pain." The goals included no avoidable falls and free of falls with injury. Interventions included, "Therapy as ordered... Amb[ulation] with FWW[front wheel walker] and 1 person assist...w/c [wheel chair] for mobility as he requests. Ability fluctuates assist with mobility as needed." There was no care plan for a tab alarm as recommended in the 1/11, "Nursing Assessment/Full." The following documentation was contained in the nurse progress notes: *1/23/08, (4:20 pm)- "Report from LPN at [3:40 pm] that resident was experiencing change of condition (lethargy, pupils constricted, small jerking movements)...Eyes rolled back in head... [Oxygen] applied [3 Liters] on. Phoned Dr. [name]. Orders received to ship to hospital. Called 911. Paramedics here at [3:55 pm]... Suspect change secondary to medication changes..." ...Condition Change form, [8:30 pm]... Returned to facility in w/c via facility van..." *1/24/08, (3:55 am)- "...still some hazy/dazed	F 323	F 323 (Continued from page 22) 4. The DON will continue to review each incident for completion of the investigation. Interventions implemented will be audited by ensuring careplan is updated and room check verifies that measures are in place. Results of audits will be reported to the monthly QA Committee meeting for 3 months, then quarterly thereafter. Date: 7/31/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 23 look/ appearance... Frequent check made, res slept well." *1/25/08- "Condition Change Form. At 3:00 am heard a loud crash sound F/B [followed by] 'Help, Help'." This RN [with] CNA found [Resident #5] right side lying on floor c/o [complaints of] extreme pain R[ight] knee. Small skin tear R elbow. He states he was trying to get his shoes on - he has a meeting. Unaware of where he is... Will have hospital administer pain med[ication] due to complications with Morphine and Amitriptyline on 1/23/08." A facility "Incident/Accident Report", dated 1/25/08, documented the same as the nursed note and also indicated the resident was near his closet/sink area in his room. The facility acknowledged in the report there had been a history of sedation in the days prior which was improving. The report indicated the future plans to use alarms to the bed and wheel chair at all times and to have nonskid mats by the bed and recliner. There were no indicators of an alarm in use at the time of the accident. A hospital discharge summary, dated 1/29/08, diagnosed "Right intertrochanteric fracture of the hip." The care plan was revised on 1/29/08 (day of readmission) and included new interventions for fall prevention. "Alarm to bed/wheelchair & recliner at all times. W/C for mobility, assist to propel. Transfers with 1 person assist & FWW..." There was no intervention for non-skid mats at the bedside or by the recliner. (These were not observed during any observation days of the survey from 6/30/08 through 7/3/08).	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 A care plan update form (5/23/08) documented, "Unaware of own safety issues at times. Has no patience or awareness of need to wait for assistance. Walks fast at times... Approaches...When up in recliner or w/c be sure he has on shoes and socks. If refuses shoes he needs non-skid socks. Remind to slow down when amb[ulates] fast." On 7/2/08 at 8:55 am, the fall and subsequent fracture for Resident #5 was discussed with the DON and RN consultant. The RN consultant asked for additional time to research the fall. The next morning the nurse consultant discussed the fall and indicated that the resident had not attempted to get up on his own. She acknowledged that the initial fall assessment had recommended a tab alarm. She also agreed that care plan interventions were not in place. The facility did not have interventions in place to prevent a fall which caused a fracture and significant pain for Resident #5. The resident did not have an alarm implemented which was recommended on his first admission. Other than one nurse progress note (1/24 above) there was no indication that on any other shift or day, nursing staff implemented frequent checks for the resident, after an episode of extreme confusion, due to a reaction to pain medication. There was no temporary care plan when he returned from the hospital and may have benefited from increased supervision. 2. Resident #2 was admitted to the facility on 11/12/07 with a diagnoses of gastrointestinal hemorrhage, hypertension, chronic back pain, severe osteoporosis, and depression. The resident was readmitted on 2/6/08 with an	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 25 additional diagnosis of fractured left hip with surgical repair. The resident's admission MDS assessment, dated 11/16/07, and readmission assessment, dated 2/10/08, documented: *extensive assistance for ADLs, *fell in past 30 days, *fell in past 31 to 180 days (2/10/08 assessment), *independent in decision making skills, *conditions/diseases make resident cognitive, ADL, mood, or behavior patterns unstable. Both assessments triggered RAPS for cognitive loss, ADL function, and falls which were addressed on the Plan of Care. Interventions for falls on the resident's 1/08 Plan of Care included: *"Non slip rug at bedside." *"Alarms for bed and wheelchair." *"Resident uses call light for assist with transfers." *"Transfer with 1 assist. Encourage to assist with transfer." The facility "Nursing Assessment/Full" was dated 12/12/07, and scored the resident a 16 for fall risk (14 + = High Risk). According to the Incident/Accident Report, the resident sustained a fall on 1/4/08 in the rehabilitation gym while ambulating in the parallel bars. The resident's "knees buckled and [physical] therapist was unable to keep pt [patient] standing so assisted pt down on pts knees on foam pad." Minor knee pain resulted. After the witnessed fall, several notations addressed the resident's need for assisted transfers. For example, the Resident Progress Notes on 1/13/08 at 4:30 am documented,	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 26 "Resident has been up to bedside commode...is able to use call light to make needs known...1 person assist /c [with] transfers to and from commode." Notes on 1/25/08 at 9:15 am documented, "Limited 1 person assist /c dressing, transfers, toileting, bed mobility. Propels self in w/c [wheelchair]." On 2/2/08 at 8:10 pm, the resident experienced an unwitnessed fall. The Resident Incident/Accident Report indicated the first responder to the incident was a CNA who documented, "[Resident] was on the toilet in her bathroom. I told her to pull the string to let me know when she was finished. Her light came on - she was on the floor by her bed - in pain - she had walked to her bed and had fallen to the floor." Immediate Actions taken after the resident's fall were vital signs, which were stable, and assessment for injury. The report indicated that based on the resident's knee and hip pain, an ambulance was called. The resident was transported to a local hospital for further evaluation. The Accident Investigation Summary of Findings, dated 2/4/08, documented,"[Resident] had reportedly been in the BR [bathroom]. CNA asked her to call for assistance when she was ready to go back to her bed. [Resident] did not call. [Resident] states she got into her wheelchair...went to the sink to wash her hands...then wheeled over to the bed. During self transfer...w/c slipped away." The report confirmed the resident had been admitted to the hospital for "L [left] hip surgical repair." The investigation report was completed and signed by the acting DON.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 27 A readmission note, dated 2/6/08 at 11:15 am, documented the resident arrived from the hospital following "L [left] hip ORIF [open reduction internal fixation]." On 7/2/08 at 8:55 am, the fall and subsequent fracture for Resident #2 were discussed with the DON and RN consultant. Both were questioned about the apparent conflict of information concerning the call light and whether the fall was during transfer or ambulation to the bed. The RN consultant, who was the acting DON at the time of the resident's fall, asked for additional time to research the requested information. The resident was asked on 7/2/08 at 10:30 am to recollect any details about the fall that resulted in her fractured hip. The resident stated that she remembered falling and going to the hospital but could not remember specific events leading to the fall. On 7/3/08 at 10:00 am, the nurse consultant stated the investigation summary documentation was incorrect. The resident had initiated her call light and "didn't wait for assistance but rather transferred herself to the wheelchair and eventually to the bed where the fall occurred." The nurse consultant acknowledged the resident had used her call light as instructed. She also stated the call light went unanswered for a length of time that could not be determined by the available documentation. The care plan was updated with the intervention, "2 person ext. [extensive] assist /c transfer" on 2/13/08, after the resident's return from the hospital. An intervention to ensure the resident	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 28 was not left unattended on the toilet/commode was lacking. Inadequate supervision and assistance with toileting contributed to the 2/2/08 fall and was not adequately addressed on the care plan to prevent future incidences. The resident had been admitted to the facility with a diagnosis of osteoporosis and a history of falls. The facility had assessed the resident at high risk for falls. Alarms and assisted transfers had been implemented. The resident had been compliant in using the call light to request assistance to the bathroom and with transfers. On 2/2/08, the resident experienced a fall that occurred after her call light was not answered immediately. The resident had initiated the call light (as instructed by the CNA) and waited for an unknown length of time before she transferred to the wheelchair, washed her hands at the sink, propelled herself to the bed, and fell to the floor attempting self-transfer. This resulted in a hospital admission for a fractured left hip repair.	F 323		
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by:	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 29 Based on observations, record reviews, and staff interviews, it was determined the facility did not ensure adequate monitoring to assess the residents' response to oxygen therapy for 2 of 11 sampled residents (#1 & 9). Findings include: 1. Resident #9 was admitted to the facility on 12/7/04 and readmitted on 5/16/07 with diagnoses of multiple sclerosis, pneumonia, chronic obstructive pulmonary disease, urinary tract infection, and dysphagia. The resident's 6/08 Physician Orders (recapitulation) documented the 12/7/07 order "O2 [oxygen] per NC prn SOB [nasal cannula as needed for shortness of breath], O2 sats [saturation levels] < [less than] 90%. Nat tutrate ti [sic][may titrate to] 3L [liters] to keep sats > [greater than] 90%. Notify MD if 3L does not bring O2 sats > 90%." The resident was observed receiving oxygen by nasal cannula at 2.5 liters per minute on 7/2/08 at 12:10 pm and again at 1:00 pm. The surveyor asked the unit LN on 7/2/08 at 1:05 pm where documentation of the resident's oxygen saturation levels were maintained. The LN stated oxygen documentation could be found on the treatment record. The oxygen order was also listed on the resident's 6/08 and 7/08 treatment records as "info only." The pre-printed treatment records contained asteriks in the boxes, precluding the option of documenting initials or other information. The treatment records did not contain oxygen saturation levels or how many liters of oxygen the resident was receiving per	F 328	F 328 1. Corrective actions for Residents # 1 and # 9 include: oxygen orders were clarified including directions for checking oxygen saturation levels and parameters for titration; and, treatment sheets were modified for documentation of saturation levels and current liter flow. 2. All residents receiving oxygen could potentially be affected. Corrective actions implemented include: oxygen orders were clarified including directions for checking oxygen saturation levels and parameters for titration; and, treatment sheets were modified for documentation of saturation levels and current liter flow. 3. Staff were inserviced regarding the assessment and documentation of oxygen saturation levels as well as the titration of oxygen levels. Admission orders will be audited following admit to ensure that required components are included and placed on the treatment sheet for monitoring. Orders and treatment sheet directives will be monitored during monthly recap process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 30 minute. An interview with the unit LN on 7/3/08 at 12:20 pm revealed the resident had been receiving oxygen on a continuous basis since 1/08. The Resident Progress Notes contained the following oxygen assessment notations for the previous 3 months: *4/1/08 at 9:30 pm - "O2 91% /c 2L via N/C." *4/8/08 at 11:00 am - "95% on 2L/NC." *5/3/08 at 4:00 pm - "93% sats." *5/5/08 at 1:00 pm - "O2 sats - 94% on 2.5L/NC." *5/21/08 (no time) - "O2 sats 92% nasal can [cannula] 2L." *5/26/08 at 4:00 pm - "O2 95% on 2L/NC." *6/26/08 at 11:00 am - "O2 94% 2L nasal canula [sic]." The progress notes indicated a sporadic documentation of oxygen saturation levels. Oxygen was increased on 5/5/08 from 2L to 2.5L without evidence of saturation levels below 90% or shortness of breath at 2L. The facility did not maintain consistent monitoring of oxygen satuation levels to effectively assess the resident's response to oxygen therapy. 2. Resident #1 was readmitted to the facility on 5/7/08 with diagnoses of pneumonia, congestive heart failure and dementia. Physician recapitulation orders for June 2008 had an order for oxygen treatment as follows: "[Oxygen per nasal canula as needed for shortness of breath, oxygen saturation levels under 90%. May titrate to 3-4 liters to keep saturation levels above 90%. Call Physician if 4 liters does not bring saturation levels over 90%]."	F 328	F 323 (Continued from page 30) 4. Corrective actions will be monitored monthly by the DON or designee and reported to the QA Committee for 3 months, then quarterly thereafter. Date: 7/31/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 31 The order was dated 5/7/08. On all days of the survey from 6/30/08 to 7/3/08 the resident was observed to receive oxygen by nasal canula. On 7/1/08 the resident received oxygen at a liter flow level of 2 liters. The surveyor left the room after that observation and went directly to the nurses' station outside of the resident's room. The resident's record was retrieved and a unit LN at the nurses' station was asked where oxygen saturation levels and liter flow were documented. The LN replied that the only place they were documented was in the nurse progress notes. The following documentation was in the nurse progress notes: *5/7/08- Two notes were written on her readmission day at 2:30 pm and 10:30 pm. At 10:30 pm a "neb[ulizer] treatment" was documented but nothing was documented concerning her oxygen treatment. *5/8/08, 11:50 am- "...96% on 4L[iters]/NC [nasal canula]..." *5/9/08, 6:40 am-"...SATS [saturation % not included] on 4 L/min...", 9:00 am- "...O2 [oxygen] SAT 94% on 4L/NC..." *On 5/10 and 5/11 she remained on 4L with SATS above 90%. There were no SATs or liter flow documented for 5/12 through 5/16 although in the 5/16/08 note "[lung sounds with crackles through out]" was documented as well as an increase in confusion and the resident hallucinating when visualizing a baby on her roommate's bed. *5/17/08 and 5/20/08 resident was on 4L and over 90%, however, there was no documentation for 2 days (5/18 and 5/19).	F 328		

PRINTED: 07/14/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 32 *5/21/08- She was changed to 3L at 100%. No reason documented for change to 3L. *5/22/08- "...90% on R/A [room air]..." *5/23/08- "...93% on 2L/NC..." No documentation if she had dropped below 90% SATS or why they needed to re-start the oxygen. *The nurse notes continued in a similar manner with no documentation regarding SATS or liter flow for dates May 24, 25, 26 and June 2, 3, 4, 5, 6, 7, 8, 11, 16, 18, 19, 21, 22, 23, 24, 25, 26, 27, 28, 29." There were no nurses notes on some of the dates, including from 6/21 to 6/25/08. The DON was interviewed on 7/3/08 at 12:00 pm. She agreed that if the resident was using the oxygen, SATS needed to be done to determine if the resident was within the parameters the physician ordered and to titrate the oxygen. The facility did not ensure that the resident's SATS were taken on a regular basis to ensure her SATS remained above 90% and determined the titration for her liter flow of oxygen.	F 328		
F 445 SS=E	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of facility policies for laundry procedures it was determined the facility did not ensure that personal laundry was processed in a way to prevent the spread of infection. This was the case for 1 of 2 laundry rooms (personal laundry room). This had the potential to affect all residents who	F 445	F 445 1. Updated written procedures to account for the limited space in the personal items laundry and to ensure the positive separation of dirty linen and tubs from clean linen and carts. Cross contamination is prevented by removing the clean linen carts from the laundry room before bringing in a tub with dirty linen. Normally, the clean linen carts are empty when placed in the hallway. Items are separated in the soiled linen room and brought in covered tubs into the personal laundry room. One tub is transferred at a time and immediately loaded into the washers. Once that load is loaded and started, the dirty linen tub is immediately returned to the soiled linen room. At this time the clean linen carts may be returned to the laundry room. The divided shelves' cart is	

PRINTED: 07/14/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 445	Continued From page 33 had personal laundry done in the facility. Findings include: Federal guidance at this regulation 483. 65(c) indicates: "The laundry should be designed to eliminate crossing of soiled and clean linen." The personal laundry room was observed on 7/2/08 at 9:10 am with the Maintenance Supervisor and one laundry room staff. This laundry room was located on the 100 hall across from the nurses' station. The room was very small. Approximately 4 feet from the door entrance there was a large commercial dryer. Next to the dryer there were 2 washing machines. On the other side of the washing machines there was a wall with some shallow shelving built in that had dividers. There were 2 covered laundry carts used to hang clean laundry and then transport it to resident rooms. One of the carts had to be removed from the room to allow enough space to stand next to the washing machine next to the dryer. There was also a barrel with dirty clothes to be sorted. There was no division of clean and dirty laundry areas in the small room. The Maintenance Supervisor said that when the dryers were loaded with freshly washed clothing or clean clothes from the dryer were hung on the carts there should not be any dirty clothing loaded in the washers. He indicated the carts should be out in the hall when dirty clothing was loaded into the washers. He indicated that a procedure on the posted on the wall directed this. The procedure was reviewed but did not indicate directives for removing carts with clean clothes to the hall when loading washing machines with dirty clothes. In addition, the divided shelves had clean clothing sorted by resident rooms and was not	F 445	F445 (Continued from page 33) stationed inside the laundry room, while the hangar cart is placed in the doorway with the open side of the hangar cart facing inward. Normally, these carts will be empty when in the hallway, except as the hangar cart is being loaded in the doorway. Clean linen carts containing clean linen may remain in the hallway no more than 30 minutes at any one time, and will remain covered except when linens are being transferred. 2. Personal laundry of all residents is affected by the corrective actions. 3. Inservice to laundry staff on updated procedures. Staff will demonstrate full understanding of procedures to supervisor's satisfaction. New employees will demonstrate proficiency before processing laundry unsupervised. 4. Maintenance supervisor will monitor and check daily for two weeks, then weekly for one month. Prevention of cross contamination during laundry processing will be added to the monthly QA Committee agenda for the next six months. Date: 7/31/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 445	Continued From page 34 removed each time a washing machine was loaded with dirty clothes. The laundry room was not designed to ensure that soiled linen would not cross contaminate clean linen.	F 445	F 456	
F 456 SS=F	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined the facility did not ensure mechanical equipment in 1 of 2 laundry rooms was maintained in safe operating condition to prevent a potential fire hazard that could affect 100% of the residents. Findings include: The personal laundry room was observed on 7/2/08 at 9:10 am with the Maintenance Supervisor and one laundry room staff. This laundry room was located on the 100 hall across from the nurses' station. The room was very small. The Maintenance Supervisor was asked how often the lint screen for the dryer was cleaned. He indicated and one laundry room staff agreed, the screen was cleaned at the end of the shift. This was the day shift. The dryer had a manufacturer instruction on it that indicated the lint screen should be cleaned at least one time a day. The Maintenance Supervisor was asked to open the dryer so the lint screen could be observed by the surveyor. There were three large wads of gathered lint on the floor under the screen. When the screen was pulled out there was an accumulation of approximately 2 - 3 inches of lint coating the screen. The	F 456	1. Inservice provided to laundry staff on correct lint removal procedures. Lint removal procedures, including diagram, posted in the laundry room located on the 100 hall across from the nurses' station. 2. Proper lint removal procedures apply to both laundry rooms. 3. End of shift log developed and posted in both laundry rooms along with lint removal procedures. Log requires staff signatures and is reviewed at the end of the month by the supervisor. Preventive maintenance task sheet implemented—to be completed monthly. All procedures will be included in new staff orientation. 4. Corrective actions will be monitored by the maintenance supervisor—daily for 2 weeks; weekly for one month; and then monthly thereafter. Proper dryer orientation will be a special interest item for the QA Committee agenda for the next six months. Date: 7/31/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 35 Maintenance Supervisor removed the lint and replaced the screen. The personal laundry room was observed on 7/3/08 at 10:30 am. This was done after the surveyor observed the dryer had been in use since entry to the facility at 9:30 am. The laundry room staff was in the laundry room and was asked if the surveyor could observe the lint screen again. She said that she had cleaned it the night before at the end of her shift. She opened the bottom of the dryer. The surveyor asked if she could remove the lint screen for observation. She said, "I'll try." She had difficulty releasing the lint screen and after several tries got it out. There was very little lint on the screen (approximately 1/4 inch build up). She then told the surveyor she just brushed the underside of the screen with a brush to remove the lint. She then tried several times to replace the lint screen. It took several attempts before she was able to get the screen back into place. The practice of brushing the bottom of the lint screen was not cleaning the screen adequately on the inside. After being cleaned out by the Maintenance Supervisor on 7/2/08 the screen did not have nearly the degree of accumulated lint on 7/3/08 after being in continuous use that morning. The accumulation of too much lint on the dryer screen created a potential fire hazard.	F 456		
F 468 SS=E	483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced	F 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 468	Continued From page 36 by: Based on observation and staff interview it was determined the facility failed to ensure that handrails were secured to walls in the 100 hall, 200 hall and the hall between two nurses' stations. This had the potential to affect any of the 11 sample residents (#'s 1 - 11) and other residents in the facility who relied on handrails for assistance with ambulation in the hallways. Findings include: The observations in common areas (hallways 100, 200 and between two nurses' stations) were completed on 6/30/08 at 11:50 am. It was noted that when leaned on or pulled, handrails were not all firmly affixed to the walls. The following areas of the facility were observed to have loose handrails: *Between the 100 hall nurses' station and room 117. *The handrail next to the boiler room door. *The handrail under the activity calendar posting and extending to the Gem dining room. *Between the linen storage cupboards on the 100 hall and room 110. *Between rooms 200 and 202, rooms 204 and 206. The administrator was advised of the problem, on 6/30/08 at 2:50 pm, regarding loose side rails. He indicated he would advise the maintenance supervisor. The next morning the administrator provided documentation that indicated the maintenance supervisor had added, "...shims and spacers between the wall and the ends of the handrails so that the rails could no longer be moved or twisted."	F 468	F 468 1. Handrails identified in this tag were assessed, and shims and spacers were added between the wall and the ends of the handrails so they cannot be moved or twisted—between the 100 hall nurses' station and room 117; the hand-rail next the boiler room; the handrail under the activity calendar posting and extending to the Gem dining room; between the linen storage cupboards on the 100 hall and room 110; between rooms 200 and 202, and rooms 204 and 206. 2. All handrails were checked. Corrective actions implemented affect all handrails. 3. Inservice to all staff on identifying loose handrails immediately to the maintenance supervisor, or by placing a note in the maintenance log. Tagout procedures apply. Monthly checks of all handrails will begin immediately as part of the preventive maintenance program. 4. Corrective actions will be monitored by the maintenance supervisor and the administrator on an ongoing basis. Handrail security will be added to the monthly Safety Committee agenda for the next six months. Date: 7/31/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State licensure survey of your facility. The surveyors conducting the survey were: Lorna Bouse, BSW, Team Coordinator Lea Stoltz, QMRP Amanda Bain, RN Rhonda Olsen, RN Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000	RECEIVED JUL 28 2008 FACILITY STANDARDS	
C 122	02.100,03,c,vi vi. May manage his personal financial affairs, and should the facility be directed by him, his family, his conservator, or guardian, to maintain a trust account for him, a report as to the status of his account and any expenditures, or access to his trust account records shall be available upon request; This Rule is not met as evidenced by: Refer to F159 as it relates to the resident right to manage personal funds.	C 122	C 122 02.100, 03, c, vi See F 159 Date: 7/31/08	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 07/28/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 143	02.100,05,c c. The patient/resident in mechanical restraints shall be checked at least every thirty (30) minutes by the staff and a record of such checks shall be kept. This Rule is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure 30 minute checks were conducted and documented while a resident was restrained with a wheelchair seatbelt. This was true for 1 of 11 sampled residents (#8). Findings include: Resident #8 was admitted to the facility on 5/6/08 with diagnoses of brain syndrome with presenile brain disease and asthma. The 5/10/08 admission MDS stated the resident experienced both short and long term memory loss, had moderately impaired cognitive skills for daily decision making, required extensive assistance for transfers and that cognitive status had deteriorated. Resident #8's 5/6/08 Plan of Care included a goal to prevent avoidable falls. Interventions to address the fall risk included use of a soft self releasing belt when up in wheelchair and instructions to release the belt and reposition the resident every 2 hours. Review of the resident's nursing assistant documentation record for 7/08 showed documentation of release from the seatbelt and repositioning every two hours the resident was in the wheelchair. No documentation of 30 minute checks were included in the records. The DON was interviewed on 7/3/08 at 10:30 and	C 143	C 143 02.100,05,c 1. Corrective actions implemented for Resident #8 include: Q 30 minute check monitor was implemented during survey. Staff were inserviced regarding the need to check this resident Q 30 minutes while wearing the seatbelt for mobility and safety. 2. All residents utilizing seat belts and other restraining devices could be affected. Corrective actions implemented for residents wearing restraining devices include: evaluation of current restraint status to ensure that least restrictive device is in place and appropriate; and implementation of Q 30 minute checks. 3. Inservice education provided to all staff regarding restraint use, and required monitoring. Admission and quarterly reviews for residents utilizing restraining devices to ensure that the least restrictive device is in place and appropriate. Careplan reviews and revisions to ensure that Q 30 minute checks continue to be documented. 4. Ongoing compliance will be monitored by: monthly audit will be completed by DON or designee to ensure that documentation of Q 30 minute checks is complete; review of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 143	Continued From page 2 confirmed the resident could not independently remove the seatbelt, and no documentation of 30 minute checks was in place for Resident #8's seat belt restraint.	C 143	C 143 (Continued from page 2) ADL flow sheet cues to provide 30 minute checks will be accomplished during the month end recap process; and, results of findings will be discussed at the monthly QA meeting for 3 months, then quarterly thereafter. Date: 7/31/08	
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure sanitary conditions were maintained in the storage and serving of all food. This had the potential to affect 100% of the residents who ate in the facility, including 11 of 11 sampled residents (#'s 1-11) . Findings include: 1. An observation was conducted in the facility kitchen on 6/30/08 at 10:10 a.m. The following were noted: a. Half full plastic bag of frozen breakfast burritos (identified by the the dietary manager) open, without label or date. b. Open plastic bag containing mixed salad greens without label or date. The dietary manager disposed of the open, unlabeled food items immediately.	C 325	C 325 02.107,08 1. Dietary manager disposed of the open, unlabeled food items (half full bag of frozen breakfast burritos and plastic bag of mixed salad greens) immediately. 2. Inservice conducted for all dietary staff about proper food storage. 3. Dietary manager or lead cook will conduct random checks 3 times a week for the next 2 months to check for proper labeling. 4. Logs of the 3x a week checks will be presented to the Safety Committee for review during the next two months. Date: 7/31/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 143	Continued From page 2 confirmed the resident could not independently remove the seatbelt, and no documentation of 30 minute checks was in place for Resident #8's seat belt restraint.	C 143		
C 325	02.107,08 FOOD SANITATION 08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure sanitary conditions were maintained in the storage and serving of all food. This had the potential to affect 100% of the residents who ate in the facility, including 11 of 11 sampled residents (#'s 1-11) . Findings include: 1. An observation was conducted in the facility kitchen on 6/30/08 at 10:10 a.m. The following were noted: a. Half full plastic bag of frozen breakfast burritos (identified by the the dietary manager) open, without label or date. b. Open plastic bag containing mixed salad greens without label or date. The dietary manager disposed of the open, unlabeled food items immediately.	C 325	C 325 02.107,08 1. Dietary manager disposed of the open, unlabeled food items (half full bag of frozen breakfast burritos and plastic bag of mixed salad greens) immediately. 2. Inservice conducted for all dietary staff about proper food storage. 3. Dietary manager or lead cook will conduct random checks 3 times a week for the next 2 months to check for proper labeling. 4. Logs of the 3x a week checks will be presented to the Safety Committee for review during the next two months. Date: 7/31/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 348	Continued From page 3	C 348		
C 348	02.108,06,a LINEN-LAUNDRY SERVICE 06. Linen-Laundry Facilities. a. The facility shall have available at all times a quantity of linen essential to the proper care and comfort of patients/residents. Linens shall be handled, processed and stored in a manner that prevents contamination and the transmission of infections. This Rule is not met as evidenced by: Refer to F445 as it relates to preventing cross contamination in the laundry room.	C 348	C 348 02.108,06,a See F 445 Date: 7/31/085	
C 351	02.108,06,a,iii iii. The laundry shall be well lighted and ventilated, adequate in size for the needs of the facility, maintained in a sanitary manner, and kept in good repair. This Rule is not met as evidenced by: Refer to F456 as it relates to maintaining the laundry room in good repair including removing lint from the dryer lint screen to prevent the potential of fire.	C 351	C 351 02.108,06,a,ii See F 456 Date: 7/31/08	
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner.	C 361	C 361 02.108,07 See F 253 Date: 7/31/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 361	Continued From page 4 This Rule is not met as evidenced by: Refer to F253 as it relates to maintenance services to provide a safe, orderly and comfortable interior.	C 361		
C 389	02.120,03,d d. Handrails of sturdy construction shall be provided on both sides of all corridors used by patients/ residents. This Rule is not met as evidenced by: Refer to F468 as it relates to handrails.	C 389	C 389 02.102,03,d See F 468 Date: 7/31/08	
C 674	02.151,01 ACTIVITIES PROGRAM 151. ACTIVITIES PROGRAM. 01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Refer to F248 as it relates to the Activity program.	C 674	C 674 02.151,01 See F 248 Date: 7/31/08	
C 745	02.200,01,c	C 745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 745	Continued From page 5 c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Refer to F281 as it relates to standards of nursing care.	C 745	C 745 02.200,01,c See F 281 Date: 7/31/08	
C 779	02.200,03,a,i i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Refer to F272 as it relates to assessment.	C 779	C 779 02.200,03,a,i See F 272 Date: 7/31/08	
C 787	02.200,03,b,iii iii. Adequate fluid and nutritional intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Refer to F312 as it relates to assistance for nutritional intake.	C 787	C 787 02.200,03,b,iii See F 312 Date: 7/31/08	
C 790	02.200,03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it relates to prevention of accidents.	C 790	C 790 02.200,03,b,vi See F 323 Date: 7/31/08	
C 795	02.200,03,b,xi xi. Bowel and bladder evacuation and bowel and bladder retraining	C 795	C 795 02200,03,b,xi See F 315 Date: 7/31/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 795	Continued From page 6 programs as indicated; This Rule is not met as evidenced by: Refer to F315 as it relates to services for restoring or maintaining bladder continence.	C 795		
C 882	02.203,02,a a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record. This Rule is not met as evidenced by: Based on record review, it was determined that the facility failed to ensure 1 of 1 closed records on a deceased resident (#12), contained a cause of death signed by the attending physician. The findings include: Resident #12 was admitted to the facility on 05/09/08 with the diagnoses of malignant neoplasm stomach, ischemic heart disease, cardiac dysrhythmias, atrial- fibrillation, and Alzheimers's dementia. Record review listed the resident expired on 05/27/08, with no medical cause of death listed	C 882	C 882 02.203,02,a 1. Resident #12's face sheet was taken to the physician, who signed the cause of death and returned it to the facility. 2. Medical records staff to d/c charts upon discharge and flag face sheet to ensure the final diagnosis or cause of death (if applicable) is listed and signed by the physician. 3. Medical records staff, as a matter of procedure, now flag each resident's chart upon discharge to ensure final diagnosis or cause of death (if applicable) is listed and signed by a physician. A signature line for the physician is added to the Record of Admission (face sheet) template to be used for all future discharges. 4. A monthly audit of all d/c charts will be performed by medical records staff for the next six months, and quarterly thereafter. Date: 7/31/08	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135020	A. BUILDING _____ B. WING _____	07/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMETT REHAB & HEALTHCARE INC	714 NORTH BUTTE AVENUE EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 882	Continued From page 7 by the physician. On 07/03/08 at 10:40 am, a medical records staff member was interviewed concerning the lack of a cause of death, signed by the physician, in Resident #12's closed record. After reviewing the closed record, the medical records staff member stated she would look for the missing documentation in the record. At approximately 12:00 pm the staff member produced a physician's signed copy of the cause of death that stated, " Advanced, metastatic esophago-gastric carcinoma." The copy was dated 07/03/08. The staff member indicated she had just called and requested the physician to sign the documentation.	C 882		
C 887	02.203,02,f f. Progress notes by physicians, nurses, physical therapists, social worker, dietitian, and other health care personnel shall be recorded indicating observations to provide a full descriptive, chronological picture of the patient/resident during his stay in the facility. The writer shall date and sign each entry stating his specialty. This Rule is not met as evidenced by: See F514 as it relates to documentation.	C 887	C 887 02.203,02,f See F514 Date: 7/31/08	